Burnett (S. G.)

THE IMPORTANCE OF A DIAGNOSIS OF MELANCHOLIA IN ITS INCIPIENCY, WITH A STUDY OF TWO CASES OF THE CONVULSIVE FORM.

BY S. GROVER BURNETT, A.M., M.D., KANSAS CITY, MISSOURI.

Professor of Physiology of the Nervous System and Clinical Neurology in the University Medical College; formerly Assistant Superintendent of the Long Island Home of New York for Nervous and Mental Diseases and Inebriates; formerly Professor of Mental and Nervous Diseases in the Kansas City Medical College.

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The main object of this paper is to present a brief study of two cases of that rare form of melancholia—namely, melancholia with convulsions. In connection with this is interwoven the importance of a diagnosis of the *incipiency* of melancholia. To treat the subject in a form of completeness a volume could be written, and for this reason the critic will bear with me in this somewhat fragmentary and disconnected presentation of a hurriedly prepared paper.

Case I.

Personal History.—Until 11 years of age nothing of interest occurs in her history, having been an average healthy child. At this age, while indulging in childish amusement, she fell from a swing with considerable violence, striking her back across a stone. Though the menstrual period had never developed prior to this, the following day a profuse flow came on, lasting several days. From the injury she was confined to bed three months, during which time she suffered much pain in the back and was unable to walk or even stand on her feet when so positioned, on account of her legs "giving way" under her weight. From this on she gradually regained the use of her limbs till no abnormality seemingly existed. But she was changed to attacks of despondency and developed an exceedingly girlish sensitiveness. Sharp remarks deeply wounded her little heart, and assertions casting perhaps jocular reflections blended her blushings with tears. In her fourteenth year the news of the sudden death of her father by accident caused her great shock and sadness. The next two years her attacks of despondency and hypersensitiveness became alarming, but she was carefully *mistreated* by able physicians, who "jollied" her friends along with the assurance that she was only hysterical; but she grew no better till in her sixteenth year, when she was taken from the old scenes and reminders of the troubles and *sadness* that had come into her young life, into a new life by travel, change of associates, new scenes, when she became a changed girl mentally and strong physically. Not, however, till after her eighteenth year did the menstrual flow become regularly established.

In the intervening years she married and has lived an average domestic life; some few clouds, perhaps, but enjoying a reasonable allotment of homelike sunshine.

Present History and Examination, February 4, 1899.—Two evenings prior to visiting my office I was entertained by the patient and her husband at the theatre. To all appearances no individual at the entertainment enjoyed it more than she did. On entering my office she did so with an *affected* cheerfulness which might have for the moment gone unobserved but for that mirrored mentality in the melancholy face. She had at last reached the degree of progress in the disease when she realized her cunningness to conceal her misfortune was lost to her; her impulses were mastering her volitional control. The morbid fears and apprehensions became so magnified as to include the every movement of her husband, as if he were a conspirator in dethroning her happiness. She knew he loved her, but, as of all others, she was suspicious of him, and especially did she know her cunning was failing her till he would detect this unexplainable something

*Read before the Jackson County Medical Society, Jul 13, 1899.

that had seized upon her. The very thought of it filled her with uncontrollable agitation and emotion and floods of tears went streaming into her lap while she wrung her hands in agony. This was a picture to behold; one that none had ever seen this estimable woman present. The detection of the melancholy trace in her face required but a few well-directed questions to readily lift the fragile vail behind which her delusional, *dual* or other self had so securely hidden from those nearest and dearest to her.

I appealed to her better judgment to overcome this exacerbation of melancholy agitation into which I had intentionally thrown her. After some effort, she did so and frankly and intelligently gave me the following history: Dating back some two years, she found herself at times subjected to annoying despondencies for which there seemed to be no particular reason. If alone, she would unconsciously drop into a distressing meditation, which, however, could be easily thrown off by voluntary effort and seeking pleasant company. But these periods were *insidiously* progressive, though always controllable. Eighteen months ago some unpleasant family happenings in tensified them to the extent that when *alone* she cried continuously, being worse at night and often awakening from a sound sleep in a flood of tears with a mingling of suppressed *fear*. Finally she was conscious of a heavy pressure, a vise-like feeling all over her head, with *severe* pain at the occipital base. During these periods the mental depression was such that she cried most of the time. From the first to the sixth of each month these head symptoms were at the climax, receding about one day, during which the menstrual flow would appear, very scant in quantity, unnatural in quality and lasting about an hour; the head *pain*, depression, crying are again at the worst for four to six days. From this to the next month the *intense* head pain is absent, but she continuously has, as she says, a "dull, heavy ache"* in the back and base of the head.

The melancholy paroxysms up to three months ago were controlled under volitional effort; that is, morbid thoughts and impulses could be dismissed from her mind and to all outward appearances she was perfectly well.

However, about this time suicidal ideas were added to her despondency and she found she could not rid herself of them. They persisted, became stronger, and when alone the impulse was so overpowering that she was terrorized. Notwithstanding this condition, she remained remarkably intelligent and would plan to escape being alone during her husband's absence, entertain her company with complacent composure, and none had the faintest conception that she was on the brink of suicide all the time.

Her husband always left a loaded revolver in the house and the very sight of it when alone terrorized her, and to escape shooting herself she would find it the effort of her life to pull herself away where she could not see it. One day while arranging her work she accidentally found a bottle of bichloride of mercury tablets, such as are used in making solutions for surgical use, and before she could restrain the suicidal impulse, she had eaten the entire contents. Miraculously, emesis immediately supervened, and no harm other than temporary indisposition resulted. She says "these thoughts" continuously worry her. She is sleepless, and should she fall asleep, the emotional horrors haunt her in dreams till it is a relief to wake again. If she goes for a drive, her impulses are to rush the horse

*This symptom was described by me as "nuchalalgia" in the "Diagnosis of Incipient Melancholia," New York *Medical Journal*, May 2, 1891. Later observations show it in other nervous affections not necessarily belonging to the melancholias.

as if flying from a pursuer, and not to return home, though she knows it is an imaginary (delusional) flight to a place of safety, she knows not where nor what for. The menstrual flow has ceased to appear, having gradually grown less as to time (days), quantity and quality. In other words, from the time mental symptoms were developed the menstrual function became deranged, and now, on the eve of a mental outbreak, the last step before public recognition and when the asylum doors are about to swing open to receive the individual, this function has ceased. This is not a *new* fact, but *common*, though rarely brought out in clinical analysis, and is mentioned as a deterrent to the operative enthusiast; the *why* is given later in the progress of the case.

Some two weeks ago while shopping she came out of the store and suddenly she was lost to the world. Though in familiar surroundings, she recognized neither things nor persons; there was no vertigo, did not fall, was not unconscious,* but a mental blank, bewilderment possessed her and she knew not where to go. While thus standing, a lady friend approached her, spoke to her, but was not recognized. She asked, "Where am I?" The friend saw there was something wrong and took her into the store, where, after a time, she came to herself, talked to her friend pleasantly, bade her good-bye and went home quite herself to all outward observation.

Again, a week ago a neighbor woman came into her house; she had known her neighbor well, but at this meeting she did not know her appearance or voice, neither did she know the person's name. In other words, she was lost to her surroundings and to herself as before. After some little time, she came to herself, recognized her friend and entertained her as usual. At these times she complained of feeling cold.

With this history and examination she left my office with an air of brightness which completely concealed her secret malady.

I at once summoned her husband and asked him if he knew the condition of his wife. He did not. In her cunning she had kept him in ignorance. He scarcely could believe my words, that his companion would, in a few days at least, be in that battle worse than death, where primitive cytoplasmic force has gone wrong, and clashing storm of cell against its neighbor cell rages from morn till night, only to come again in dreams till breaking morning light.

This was on Saturday. The next Monday she came to my office with her husband in a restless, agitated state, inclined to say nothing unless urged to talk. Facial expression markedly melancholic and flushed. Marked vaso-motor disturbance. She complained of being chilled all the time and begged to have the "awful pain" in the back of her head relieved. I put her on the insulated stool and gave her the static breeze over her head fifteen minutes, during which time all agitation subsided, the chill was replaced by a soothing warmth, and she said, "I 'm so comfortable; let me alone and I will go to sleep." The former affected cheerfulness is not present, but when she talks she is perfectly rational and appreciates she is losing her mind. The next evening I was called to the house. She passed a bad night. She is in a severe state of agitation and knows no one. Hallucinations of hearing and delusions of persecution are acute; she thinks she hears some one knocking and calling for her; that friends have deserted her; that persons are coming to put her in irons, and begs piteously not to be put "behind bars"; she keeps calling her husband and viciously repels him and pleads and cries for him to come and

*She says she was not unconscious, but her mind was a blank for the time being, same as in the psychical form of epilepsy.

save her from "this strange man"; she talks to her dead mother's voice and thinks she has come back to her; that she must not eat any more because everything she has eaten in seventeen years is collected in her head and causes all her trouble. She constantly begs to be relieved of the pain in the back of her head, and calls for the revolver, saying, "I could fix the pain so quick." She says she has "hunted the house from top to bottom, but can't find that gun"; she chastises herself for not using it when she had it. She begs me for a knife or a "rope in the cellar."

This condition lasted till the third day, when she somewhat simulated the stuporous form; would not talk, but answered by signs, motioned to real and imaginary things or persons, and would eat nothing. If her husband comes in with his coat on, she becomes frenzied; but with his coat off she clings to him as a protector against expected danger. The refusal to take food was readily overcome by promptly feeding through a stomach-tube.

The one predominating symptom was the head pain, constantly present and at intervals undergoing exacerbation. In the earlier stages the severe pain was preceded by vasomotor disturbance, such as burning heat sensation and skin irritation, followed by chilly manifestation, which toward the last amounted to a slight shiver. This caused the most intense psychic and motorial agitation, requiring the nurse to use force to hold her in bed. From the first there was always some tenderness of the cervical spines and a drawing sensation of the head back. This, also increased in intensity. In fact, these attacks of pain, brought on by any sudden start, noise or fright, were the avenue to every thing undesirable mentally and on the fourth day they were merged into convulsions, beginning with a slight general tremor and becoming generalized in convulsive form. She was at this time clearer mentally; that is, not stuporous or cloudy in expression, being brighter perhaps at about the time the convulsion would come on. The convulsion was preceded by awful pain in the head and a premonition of fright, a terrorized helplessness in the presence of impending danger, vasomotor spasm and chilling followed by a vigorous tremor, gradually becoming of a general convulsive type with some oposthotonous at times. Consciousness was seemingly not lost at first in the lighter forms, but as the seizure subsided the patient relaxed into a limp, listless, unconscious state in which respiration seemed suspended for a period that became alarming. The lips were blue, eyes staring and glassy and a small, weak, compressible half-filled pulse that became difficult to count. There was no biting of tongue or frothing of the mouth, but there was seen active contraction and relaxation of the pupils, which always are present in the post-convulsive stage of the epileptic seizure, regardless of the degree of light thrown on the pupil.

At first the convulsions might have been mistaken for the major hysterical manifestation, but the final developments of cyanosis and collapse as described do not belong to hysteria. The possibility of a meningitis was considered on account of the severe pain, pulling back of the head and oposthotonous, but there was no temperature, neither had there been any.

The convulsions were partly controlled by bromide and chloral, but, owing to the acuteness of the melancholia, the rapid sinking of the general strength and the malassimilation, as little heavy dosing as possible was desirable; besides, they did not relieve the pain. Dr. Block was asked to see the case and an agreement was made to discontinue everything and give morphia hypodermically sufficient to control pain. She

rested well for some twenty hours, when, on waking in the morning, she had a worse convulsion than any before, followed by cyanosis, suspended respiration and failure of pulse, requiring artificial respiration for some minutes to revive her. Her temperature immediately went to 100° F., when reaction set in with pulse 104, with temperature falling to 98½° in an hour. I saw her at 10 a. m., and on account of her failing condition remained till afternoon lunch. At 11 o'clock her pain at the base and under surface of the brain became severe and morphia was given to quiet it; though quieted from the morphia, two hours later complete collapse followed a hard convulsion. Cyanosis could not have been more intensified had she been strangled by hanging. Respiration ceased entirely. Radial pulse was gone and the only visible sign of life was a faint heart-beat. Artificial respiration was kept up for one and three-quarters hours before the faintest trace of life was manifest. Dr. H. B. Coleman came to my rescue when I had given out, and kept up the seemingly hopeless effort to restore life. In addition to artificial respiration, I gave four hypodermics of sulphuric ether, which has served me as a diffusible stimulant in several cases of collapse as nothing else has. The first exhalation attempted impressed me much like taking a full breath over the mouth of the open ether can, the exhaled air being so loaded with the fumes of ether. The temperature during collapse went to 101° F., falling again as before and soon becoming normal.*

From this on all opiates were discontinued, regardless of pain. Enemas of a bromide-chloral combination were given to control convulsive tendency, which persisted for three or four days. Twenty-grain doses of sulphonal were given night and morning, giving good sleep and markedly reducing the agitation.

Following the convulsion in the morning, requiring a few minutes' artificial respiration, marked swelling and ptosis of both eyelids supervened. The pupils were widely dilated, but reacted tardily to light. Patient could not see anything more than she could tell when facing the window and remained without vision some two weeks, when her sight came to her gradually. No ophthalmoscopic examination was made.

The severe pain gradually subsided into the dull heavy ache, and as she neared recovery faded away in gradations much the same as it insidiously came on.

After three months she had quite recovered, excepting at the menstrual period and other slight causes of depression, when a slight melancholy tendency is manifest. Now, after five months, she seems almost as well as at any time in her former life.

Case II.

Personal History.—Housewife, aged 27 years. During childhood she had children's diseases, such as whooping-cough and measles, but matured an average healthy girl. In temperament she was timid, reserved, feelings easily hurt and not inclined to seek amusements like some do. She married at 16 years of age, and became a mother at 17, and again at 20 years. After this she says her husband was unkind to her, over which she fretted, became nervous, lived unhappily and accordingly avoided the pregnant state again for four years, her husband deserting her when she was pregnant. She became desperate, suffered self-inflicted abortion, almost losing her life, divorced herself and remarried her husband within a year. But the end was not yet, and the domestic threshold was bordered by a skirmish line of infelicity.

*Urinary examination was negative.

Two months following recovery from the abortion she flowed seemingly normally, but after that irregularity as to time, quan tity and quality insidiously set in, and ten months ago (twenty-six months after the abortion), the last trace of the flow was seen.

Examination.—Examination of pelvic organs revealed no cause for cessation of menstrual flow. She feared pregnancy unnecessarily. During the period when menstruation should come on much nervous disturbance is manifest. She has a dull, heavy occipital pain with tendency to extend forward in its climax along the floor of the skull, with exceedingly sharp shooting pains through the level of both eyes—sub-temporal. This severe pain is sudden, without warning and accompanied by crossed binocular diplopia, dimness and finally extinction of vision, temporary loss of remembrance with tendency to sleep for an hour or two, after which she gets up feeling better till the next attack comes on. She does not always lose her self, and then does not sleep afterwards, though there is excessive pupillary contraction and relaxation, regardless of the amount of light thrown on the pupil.

Her facial expression has a dim, melancholy trace, but she affects cheerfulness; her perceptions are acute, conversation connected and misleading on account of the intelligence shown; but further examination revealed the following: She was never able to sleep after midnight for four months after menses ceased. Three months ago, when she did fall asleep she was tortured by "night-horrors," frightful and terrorizing dreams. These became so real that with the utmost difficulty could she be reasoned out of them. Though she would acknowledge their fallacy, again she would secretly, in her own mind, have much fear and trepidation as to her conclusion. Two months ago despondency was linked to the chain. She said thoughts of the dreadfulness of having to leave her children filled her mind. Mental depression and sadness, for which there was no real cause, hung over her. At first she could get rid of it, but finally it persisted, and much of the time she was in fear, expectant dread and desperation.

All this I obtain from her in a reasoning state of mental composure. I here told her frankly I wanted her to tell me truthfully not *when*, but *how* she had frequently planned to take her own life. Like the approaching shadow from the cloud obscuring the sunshine, her whole expression changed to dejection, fear and agitation; tears rolled down her cheeks and as she sat wringing her hands she accused me of having some secret way of knowing her affairs. I assured her not, but that one in her condition could not help having suicidal ideas running through her mind; that she was not personally responsible and must tell me all. She then confessed the presence of the suicidal impulse as being overpowering; that she tried every way to get laudanum to kill herself with; that in its absence she determined to throw herself in the cistern, but did not get the opportunity to do so without detection till the impulse had left her. Three weeks ago it came on her again, and though she wanted to die, she was living in constant dread of some impending calamity to befall her. Her mother, who was present, assured me none of them had suspected any mental trouble, and that the extreme agitated melancholia now shown and the confession was a shock to her.

Remarks.—The student of mental diseases will at once recognize in the foregoing cases typical pictures of incipient melancholia agitata plus the convulsive condition, the latter to be referred to later. In both cases the diagnosis was made before the melancholy outbreak. Their very closest family associates, the husband of Case I. be-

ing an able physician, had not suspected mental disease. Were I asked the *real scientific province* of the neurologist, I would say it was the *ability* to diagnose the disease in the *incipiency*. Especially is this important in its relation to the prognosis of melancholia. I have referred to this before,* but it can't be too often refreshed in our memories.

The wave of suicides just past that has filled our daily papers with profound mysteries was nothing more than the harvest of undiagnosed cases of incipient melancholia. It is the stage of the disease when they take their own lives or a mother or father murders the whole family and then takes his or her own life. Of all forms of mental disease this is perhaps the most dangerous as to the commission of suicide and murder because of its insidious onset. It creeps into the household as a hidden viper, and its first presence is manifest, oftentimes, only by the stroke of the deadly fangs carrying the poison of death—the suicidal stroke. Other forms of mental disease are less in tendency to suicide and murder, and when so inclined the act is not a shrewd, cunning, secretly planned and carried out impulse; it is open, bold and boasted of, and thus easily prevented. The great *mental* pain in Case II. was the awful sadness that overwhelmed her at the thought of leaving her children. She was thrust into the most profound grief. Every sound, their little prattle and tuneful voices that were once the pride, sunshine and joy of her life, would give her nothing but mental pain and distress. No mirthful sensation could reach her mind without undergoing transformation into one of mournful tint and hue in its passage through the melancholiaized cortex. To rid herself of this mental pain, her false but quiet and unrevealed reasoning to those about her led her to conjure the plan to first destroy her children and then herself. My discovery of her suicidal state of mind by some secret way of finding out her plans, as she accused me, caused her equally as much mental pain and uncontrollable agitation.

Convulsions in Melancholia.—So far as I am able to ascertain, Dr. S. S. Clouston, superintendent of the Royal Edinburgh Asylum, is the only authority who has described this form of melancholia. It is, fortunately, rare, but to my thinking it is more frequent than is generally supposed. Owing to want of interest and analytical learning, which is only obtained by actual, long-continued and systematic bedside observation, it is frequently unrecognized. In fact, the average so-called alienist, whose course of training in psychology is limited to a short term of service doing the reverential salaam of the Orient to the political gods, is sufficiently classic if he diagnoses a *melancholia*, without attempting to recognize its different forms. The condition of motor excitement under consideration is not the voluntary, ideo-coördinated movement of emotion—mental depression with retained consciousness and memorized acts—but it is a convulsive motor excitement, rather sudden in its onset, with complete or incomplete unconsciousness. I make this statement because Case I. had numerous light (petit mal) seizures without entire loss of consciousness. Case II. had some attacks in which she claimed to not be unconscious, but while these were also of the petit mal type, consisting of sudden turning of the head, rolling of the eyes, slight facial twitching and pallor, a heavy sigh and then looking blankly about as if lost, there was evidently a period of unaccountability. The convulsion, if classified, is epileptoid in character. Clouston regards its presence indicative of the most serious form of melancholia: "In it the whole of the functions of

*New York *Medical Journal*, May 2, 1891, "Diagnosis of Incipient Melancholia."

a brain convulsion are affected—mental, motor, sensory, trophic and vaso-motor." The physical and mental agitation and mental depression are profound, and where the melancholy outbreak fully develops great stubbornness and resentment occurs. Case I. would eat nothing till overpowered and fed with a stomach-tube. Also in both cases there was marked vaso-motor defect, some skin-irritation and lessened sensibility to pain in general, excepting the severe exacerbations of head-pain which preceded the convulsions.

Clouston's cases, he says, seldom had more than one or two convulsions. I take this to mean typical convulsions, for he speaks of one case "having many." Both Cases I. and II. had many seizures, though Case I. only had perhaps not to exceed six hard ones, two of which were followed by the suspension of radial pulse, respiration, deep cyanosis, and required artificial respiration both times, the last time it being kept up, as before stated, one and three-fourths hours before any signs of life were manifest. In both of these seizures the temperature went up, in the first to 100° F., and in the second to 101° F., but falling again shortly after resuscitation. Otherwise there was no temperature. In Case I. the convulsions appeared on the fifth day after the melancholy outbreak. In Case II. they appeared three months before my seeing her, at which time the melancholy outbreak had not yet occurred and her insanity had not been detected. And in a third case, of which I took no history, the convulsions preceded the melancholia some two months.

Pathology.—The three cases I have seen are still living, and consequently no post-mortem knowledge is obtainable. Clouston only examined one case post-mortem that did not show "cause of irritation or some limited adhesion of the pia mater to the convolutions." This pathological change was not unlike that found in general paresis, but differing as to the location, being always on the *basal convolution* and not over the vertex as in paresis. This is of interest when remembering the basal pain, exacerbations which always preceded the convulsion in both cases; and in Case I., in the two severe convulsions described as requiring artificial respiration, there was the rise of temperature for the time being, not only indicative of an irritation, but possibly an advance to localized inflammation of a minor degree. On microscopic examination, Clouston found "proliferation of the nuclei of the neuroglia, especially seen round the arterioles and capillaries, with destruction of many of the nerve-cells." In one case, dying at 71 years of age of chronic melancholia after two convulsions twenty years apart, several bony spicules were found in the dura projecting into the motor cortex. Pia was not adherent and no granulations of the ventricles existed. Microscopically "the pia was thickened, with blood between its two layers in some places." There was a sclerosed layer on the surface of the cortex, with marked enlargement of the pericellular spaces," much atrophy of the cell substance in all the layers of the cortex and pigmentary degeneration of the large cells of the third layer."

Prognosis.—Necessarily the prognosis is one to be dreaded as far as ultimate recovery is concerned. However, I am inclined to believe that a diagnosis of the disease in its *incipiency* and its treatment *carefully* and *systematically* carried out remote from asylum association can not help changing largely the heavy footing of chronics to the column of recoveries. The more I compare the statistics of my private cases treated on the "home" plan with those of my asylum service, the more I am convinced that the many relapses leading to chronicity should not

have occurred remote from the asylum influence. I believe the very fact of a patient being firmly impressed that he is an insane man by coming to himself within the walls of an asylum produces a mental shock and so stigmatizes his future beyond any possible reparation. This, added to the fact that our asylums are overcrowded places of detention and it is necessarily impossible to carry out close, systematic observation of each individual case, is a broad, unpolished hint as to *why* we have so many chronic insane. The presence of this awful army has made our classical generals think and wake up to the realization than brain tissue enjoys no higher exemption from functional and organic disease than lung, kidney or liver tissue; and still what great minds would think of letting the latter run well through the acute stage of the affection and then send them to places of comfortable detention and anticipate a good prognosis? So long as we fail to recognize mental disease till the patient has gone rampant and wild; so long as we fail to treat them scientifically, more carefully and more systematically, be it possible, than we would treat a case of typhoid fever or pneumonia; just so long must we bite our lips in silence in answering the question of prognosis in these cases.

I have learned to realize that a diagnosis of melancholia in its incipiency and immediate care given in privacy will almost insure a favorable prognosis. The per cent of recovery is remarkable. Since January this year I have received nine cases of melancholia presenting practically equal chances for recovery. Three of the nine were too poor to pay for their care at my Retreat and were sent to the public asylum. At this writing I am informed they are still mentally unimproved. The other six have been sent home to all appearances well.

While Clouston gives an unfavorable prognosis in the convulsive form, which is borne out by his statistics, my two cases have both recovered from the melancholia and are seemingly well. While they have returned to their homes and are both in charge of their family duties, I am reluctant to say they will not relapse. They may not, but it is only reasonable to believe that a deranged mentality, based on pathological changes, though the process may have become passive—dormant, might be again renewed by the taxation of the wear and tear of life, or by returning to the surrounding influences that fostered the primary attack.